

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6800

## CERTIFICATE OF DEATH

Reg. Dist. No.

06770

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>				d. STREET ADDRESS <u>17X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>E</u> Last <u>BASH</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 30 1876</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>EDWARD H BASH</u>				14. MOTHER'S MAIDEN NAME <u>MARY KER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>SPANISH-AMER NONE</u>		17. INFORMANT <u>HOSPITAL RECORDS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC MYOCARDITIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL HEMORRHAGE</u> DUE TO (c) <u>CEREBRAL ARTERIOSCLEROSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 WEEKS</u> <u>OVER 4 1/2 YRS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRAIN SYNDROME</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>APR 25</u> , 1957, to <u>JUNE 17</u> , 1958, that I last saw the deceased alive on <u>JUNE 16</u> , 1958, and that death occurred at <u>1:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry J. Crawford</u>				ADDRESS (Street, city or town, state) <u>ESS HOSPITAL</u>		DATE SIGNED <u>JUNE 17, 1958</u>	
PHYSICIAN'S NAME (Type) <u>HARRY J. CRAWFORD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 18, 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centreville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Butler, Jr. of Butler Bros., Centreville, Md.</u>				24a. REG'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

<p>1. NAME OF DECEASED                  JAMES M. SMITH</p>		<p>2. SEX                  Male</p>		<p>3. AGE                  45</p>	
<p>4. DATE OF DEATH                  Jan 15 1900</p>		<p>5. TIME OF DEATH                  10:30 AM</p>		<p>6. PLACE OF DEATH                  Home</p>	
<p>7. CAUSE OF DEATH                  Heart Disease</p>		<p>8. DISEASE OR INJURY                  Myocardial Infarction</p>		<p>9. MANNER OF DEATH                  Natural</p>	
<p>10. SIGNATURE OF PHYSICIAN                  J. M. Smith</p>		<p>11. SIGNATURE OF WITNESSES                  J. M. Smith</p>		<p>12. SIGNATURE OF DECEASED                  J. M. Smith</p>	
<p>13. SIGNATURE OF REGISTRAR                  J. M. Smith</p>		<p>14. SIGNATURE OF CLERK                  J. M. Smith</p>		<p>15. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>16. SIGNATURE OF JURY                  J. M. Smith</p>		<p>17. SIGNATURE OF JURY                  J. M. Smith</p>		<p>18. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>19. SIGNATURE OF JURY                  J. M. Smith</p>		<p>20. SIGNATURE OF JURY                  J. M. Smith</p>		<p>21. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>22. SIGNATURE OF JURY                  J. M. Smith</p>		<p>23. SIGNATURE OF JURY                  J. M. Smith</p>		<p>24. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>25. SIGNATURE OF JURY                  J. M. Smith</p>		<p>26. SIGNATURE OF JURY                  J. M. Smith</p>		<p>27. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>28. SIGNATURE OF JURY                  J. M. Smith</p>		<p>29. SIGNATURE OF JURY                  J. M. Smith</p>		<p>30. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>31. SIGNATURE OF JURY                  J. M. Smith</p>		<p>32. SIGNATURE OF JURY                  J. M. Smith</p>		<p>33. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>34. SIGNATURE OF JURY                  J. M. Smith</p>		<p>35. SIGNATURE OF JURY                  J. M. Smith</p>		<p>36. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>37. SIGNATURE OF JURY                  J. M. Smith</p>		<p>38. SIGNATURE OF JURY                  J. M. Smith</p>		<p>39. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>40. SIGNATURE OF JURY                  J. M. Smith</p>		<p>41. SIGNATURE OF JURY                  J. M. Smith</p>		<p>42. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>43. SIGNATURE OF JURY                  J. M. Smith</p>		<p>44. SIGNATURE OF JURY                  J. M. Smith</p>		<p>45. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>46. SIGNATURE OF JURY                  J. M. Smith</p>		<p>47. SIGNATURE OF JURY                  J. M. Smith</p>		<p>48. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>49. SIGNATURE OF JURY                  J. M. Smith</p>		<p>50. SIGNATURE OF JURY                  J. M. Smith</p>		<p>51. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>52. SIGNATURE OF JURY                  J. M. Smith</p>		<p>53. SIGNATURE OF JURY                  J. M. Smith</p>		<p>54. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>55. SIGNATURE OF JURY                  J. M. Smith</p>		<p>56. SIGNATURE OF JURY                  J. M. Smith</p>		<p>57. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>58. SIGNATURE OF JURY                  J. M. Smith</p>		<p>59. SIGNATURE OF JURY                  J. M. Smith</p>		<p>60. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>61. SIGNATURE OF JURY                  J. M. Smith</p>		<p>62. SIGNATURE OF JURY                  J. M. Smith</p>		<p>63. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>64. SIGNATURE OF JURY                  J. M. Smith</p>		<p>65. SIGNATURE OF JURY                  J. M. Smith</p>		<p>66. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>67. SIGNATURE OF JURY                  J. M. Smith</p>		<p>68. SIGNATURE OF JURY                  J. M. Smith</p>		<p>69. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>70. SIGNATURE OF JURY                  J. M. Smith</p>		<p>71. SIGNATURE OF JURY                  J. M. Smith</p>		<p>72. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>73. SIGNATURE OF JURY                  J. M. Smith</p>		<p>74. SIGNATURE OF JURY                  J. M. Smith</p>		<p>75. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>76. SIGNATURE OF JURY                  J. M. Smith</p>		<p>77. SIGNATURE OF JURY                  J. M. Smith</p>		<p>78. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>79. SIGNATURE OF JURY                  J. M. Smith</p>		<p>80. SIGNATURE OF JURY                  J. M. Smith</p>		<p>81. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>82. SIGNATURE OF JURY                  J. M. Smith</p>		<p>83. SIGNATURE OF JURY                  J. M. Smith</p>		<p>84. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>85. SIGNATURE OF JURY                  J. M. Smith</p>		<p>86. SIGNATURE OF JURY                  J. M. Smith</p>		<p>87. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>88. SIGNATURE OF JURY                  J. M. Smith</p>		<p>89. SIGNATURE OF JURY                  J. M. Smith</p>		<p>90. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>91. SIGNATURE OF JURY                  J. M. Smith</p>		<p>92. SIGNATURE OF JURY                  J. M. Smith</p>		<p>93. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>94. SIGNATURE OF JURY                  J. M. Smith</p>		<p>95. SIGNATURE OF JURY                  J. M. Smith</p>		<p>96. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>97. SIGNATURE OF JURY                  J. M. Smith</p>		<p>98. SIGNATURE OF JURY                  J. M. Smith</p>		<p>99. SIGNATURE OF JURY                  J. M. Smith</p>	
<p>100. SIGNATURE OF JURY                  J. M. Smith</p>		<p>101. SIGNATURE OF JURY                  J. M. Smith</p>		<p>102. SIGNATURE OF JURY                  J. M. Smith</p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

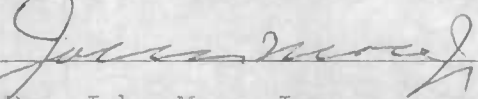
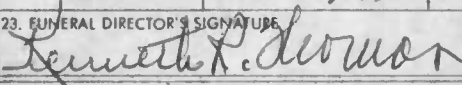
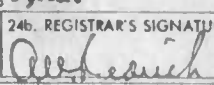
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06771  
Reg. Dist. No. **06771**

**6777**

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>25 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>				d. STREET ADDRESS <b>23 High Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alverda</b> Middle <b>Dunbar</b> Last <b>Bayly</b>				4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 18, 1874</b>		9. AGE (In years last birthday) <b>84 yrs.</b>	
				IF UNDER 1 YEAR Months <b>84</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cambridge</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Alexander Hamilton Bayly</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Craig</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Ann Lloyd Slagle, Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <b>Fracture neck femur 904.0</b>							NO. OF DAYS ELAPSED <b>27</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Slipped and fell in her home, unable to arise.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>3 P.M.</b> May <b>31</b> 19 <b>58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Cambridge, Dor. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE 		EXAMINER'S NAME (Type) <b>Dr. John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/30/58</b>	
				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 14, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Christ Churchyard</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE 				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 7 '58</b>	
						24b. REGISTRAR'S SIGNATURE 	

TWO for one certificate Film G231 - 7/11/58-mb

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6778

Reg. Dist. No. 06772

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>127 Washington Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Minnie Bishop Bowley</u>		4. DATE OF DEATH <u>June 26, 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1894</u>
9. AGE (in years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Bishop</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bishop</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-10-6166</u>	
17. INFORMANT <u>Thomas Bowley, Cambridge, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/27/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/30/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard M. [Signature]</u>		24a. REC'D BY REGISTRAR <u>W. [Signature]</u>	
ADDRESS <u>Cambridge, Md.</u>		DATE <u>JUL 8 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

RECORDS AND COLLECTIONS

Form with various fields for medical examination and death certification, including checkboxes and signature lines.

DATE OF DEATH: \_\_\_\_\_

TIME OF DEATH: \_\_\_\_\_

PLACE OF DEATH: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

MANNER OF DEATH: \_\_\_\_\_

SIGNATURE OF EXAMINER: \_\_\_\_\_

DATE: \_\_\_\_\_



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6801

CERTIFICATE OF DEATH

06773

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rhodesdale - Rural</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eldorado</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>Victoria</b> Last <b>Boyce</b>				4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>58</b> 19			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 14, 1875</b>		9. AGE (In years last birthday) yrs. <b>82</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Marine</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Fisher</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>L. Curtis Boyce, Rhodesdale, Maryland, RFD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>General arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <b>6 June, 1958</b> , to <b>13 June, 1958</b> , that I last saw the deceased alive on <b>6 June, 1958</b> , and that death occurred at <b>11:40 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. R. Trapnell</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>126 Bloomingdale Federalsh</b> <b>6-14-58</b>			
PHYSICIAN'S NAME (Type) <b>H. R. Trapnell, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 16, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Eldorado Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Eldorado, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>				24a. REG'D BY REGISTRAR DATE <b>JUN 20 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Smith</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6802

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge RFD # 2</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge RFD # 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge RFD # 2</u>				e. STREET ADDRESS <u>Cambridge RFD # 2</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Byron</u> Middle <u>A.</u> Last <u>Cameron</u>		4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>19 58</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/2/66</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Game Warden</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Game</u>		11. BIRTHPLACE (State or foreign country) <u>Ray Brook, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Duncan Cameron</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Ames</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Donald D. Cameron</u>		17. INFORMANT <u>Cambridge RFD # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Sudden</u> Interval between onset and death <u>Sys.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>19</u> Hour <u>o. m.</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/13/54</u> , 19 <u>54</u> , to <u>6/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/9/58</u> , 19 <u>58</u> , and that death occurred at <u>9:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>136 Ruse St. Cambridge, Md</u> DATE SIGNED <u>136 Ruse St. Cambridge, Md</u>							
ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D.		DATE SIGNED <u>136 Ruse St. Cambridge, Md</u>					
PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u>		DATE SIGNED <u>136 Ruse St. Cambridge, Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>North Elba Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lake Placid, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 2 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. E. Smith</u>			

CERTIFICATE OF DEATH

8803

For Use by

<p>1. NAME OF DECEASED <i>JOHN J. SMITH</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>Jan 15 1950</i></p>		<p>5. TIME OF DEATH <i>10:30 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. OCCASION OF DEATH <i>Heart Disease</i></p>		<p>8. CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>9. MANNER OF DEATH <i>Natural</i></p>	
<p>10. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>11. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>12. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>13. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>14. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>15. SIGNATURE OF WITNESS <i>John J. Smith</i></p>	
<p>16. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>17. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>18. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>19. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>20. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>21. SIGNATURE OF WITNESS <i>John J. Smith</i></p>	
<p>22. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>23. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>24. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>25. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>26. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>27. SIGNATURE OF WITNESS <i>John J. Smith</i></p>	
<p>28. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>29. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>30. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>31. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>32. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>33. SIGNATURE OF WITNESS <i>John J. Smith</i></p>	
<p>34. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>35. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>36. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>37. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>38. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>39. SIGNATURE OF WITNESS <i>John J. Smith</i></p>	
<p>40. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>41. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>42. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>43. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>44. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>45. SIGNATURE OF WITNESS <i>John J. Smith</i></p>	
<p>46. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>47. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>48. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>49. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>50. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>51. SIGNATURE OF WITNESS <i>John J. Smith</i></p>	
<p>52. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>53. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>54. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>55. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>56. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>57. SIGNATURE OF WITNESS <i>John J. Smith</i></p>	
<p>58. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>59. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>60. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>61. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>62. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>63. SIGNATURE OF WITNESS <i>John J. Smith</i></p>	
<p>64. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>65. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>66. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>67. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>68. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>69. SIGNATURE OF WITNESS <i>John J. Smith</i></p>	
<p>70. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>71. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>72. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>73. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>74. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>75. SIGNATURE OF WITNESS <i>John J. Smith</i></p>	
<p>76. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>77. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>78. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>79. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>80. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>81. SIGNATURE OF WITNESS <i>John J. Smith</i></p>	
<p>82. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>83. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>84. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>85. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>86. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>87. SIGNATURE OF WITNESS <i>John J. Smith</i></p>	
<p>88. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>89. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>90. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>91. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>92. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>93. SIGNATURE OF WITNESS <i>John J. Smith</i></p>	
<p>94. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>95. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>96. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	
<p>97. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>98. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>99. SIGNATURE OF WITNESS <i>John J. Smith</i></p>	
<p>100. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>101. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>102. SIGNATURE OF DECEASED <i>John J. Smith</i></p>	

STATE OF MARYLAND

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO KEEP THIS RECORD AND TO MAKE IT AVAILABLE TO THE PUBLIC. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6803

CERTIFICATE OF DEATH

Reg. Dist. No.

06775

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>				c. LENGTH OF STAY IN 1b <u>9 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>				d. STREET ADDRESS <u>FEDERALSBURG 05X-2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ALEXANDER</u> Middle <u>LINCOLN</u> Last <u>CHERRY</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 20 1871</u>	
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL WORKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WESTINGHOUSE CO.</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>THOMAS CHERRY</u>				14. MOTHER'S MAIDEN NAME <u>JANET GILCHRIST</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HOSPITAL RECORDS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MITRAL STENOSIS</u> DUE TO (c) <u>UNKNOWN</u>				INTERVAL BETWEEN ONSET AND DEATH <u>54 HOURS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490X CHRONIC BRAIN SYNDROME WITH SENILE BRAIN DISEASE</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>APR 22, 1957</u> , to <u>JUNE 9, 1958</u> , that I last saw the deceased alive on <u>JUNE 8, 1958</u> , and that death occurred at <u>1:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Harry J. Crawford</u> M.D. <u>ESS HOSPITAL - CAMBRIDGE, MD JUNE 9 1958</u>							
PHYSICIAN'S NAME (Type) <u>HARRY J. CRAWFORD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 11, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MILFORD, DELAWARE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Hampton Lee</u>				ADDRESS <u>Federalburg Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 12 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>Deed Smith</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6804 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN lb <b>6 yr.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>				d. STREET ADDRESS <b>-</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Ella</b> Middle <b>Virginia</b> Last <b>Coleman</b>				4. DATE OF DEATH Month <b>June</b> Day <b>24</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-3-65</b>	
9. AGE (In years last birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>George Satterfield</b>				14. MOTHER'S MAIDEN NAME <b>Ella Eisenbrey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Records E.S.S.H.</b>		Address <b>Cambridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b>							
904.7 DUE TO <b>Fracture Neck l. femur</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>2 Mo.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic myocarditis ?</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pushed by another inmate and fell to floor.</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>6 AM</b> p. m. <b>4-24- 19 58</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	
20f. (City or town) <b>Cambridge</b>				20g. (County) <b>Dor.</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John Mace Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>6/26/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Resley Chapel</b>	
22d. LOCATION (City, town, or county) <b>Rock Hall</b>				22e. (State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. L. Lane</i>				ADDRESS <b>Chorch Hill</b>		24a. REC'D BY REGISTRAR <b>JUN 30 '58</b>	
				24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your own use prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

## PHYSICIAN EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased _____		Date of Death _____	
Place of Death _____		Age of Deceased _____	
Sex of Deceased _____		Race of Deceased _____	
Cause of Death _____		Manner of Death _____	
Signature of Physician _____		Signature of Examiner _____	
Date of Certificate _____		Place of Signature _____	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06777

6805

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock - Rural</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harrison Ferry</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Leila Mae Conway</b>		4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 20, 1872</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert H. Conway</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Medford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Olin P. Conway, Hurlock, Maryland, R.F.D.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Congestive Failure</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Cystitis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>? 2 weeks</b> <b>? 20 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 30, 1958</b> , to <b>June 1, 1958</b> , that I last saw the deceased alive on <b>May 30, 1958</b> , and that death occurred at <b>10:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Preston, Md.</b> DATE SIGNED <b>6-3-58</b> ACTUAL SIGNATURE <b>Jay B. Plummer</b> M.D.			
PHYSICIAN'S NAME (Type) <b>DR. H. B. PLUMMER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 3, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Saint Paul Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Hurlock, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalsburg, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JUN 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arch</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6779

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>212 Pine St.</u>				d. STREET ADDRESS <u>212 Pine St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marguerite S. Cornish</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1924</u>		9. AGE (In years last birthday) <u>33</u> yrs.	IF UNDER 1 YEAR Months <u>33</u> Days <u>33</u>	IF UNDER 24 HRS. Hours <u>33</u> Min. <u>33</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food packing</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Richard Sharp</u>				14. MOTHER'S MAIDEN NAME <u>Mary Roberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-01-2883</u>		17. INFORMANT Address <u>Edward Cornish 212 Pine St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 Hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>6/9/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cordtown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cordtown, Dor. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert St Clair</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 11 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

WESTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.



Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, date of death, and cause of death. The form is divided into several columns and rows, with checkboxes for various conditions and a large area for the examiner's signature and notes.

6780

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenburn Convalescent Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Hamilton</u> Last <u>Cosby Jr.</u>				4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/16/87</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Milton N.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John H. Cosby Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs John H. Cosby Jr.</u> Address <u>127 High St. Cambridge Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure &amp; uremia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic C.V.D.</u> DUE TO (c) <u>Arterio-sclerotic gen.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 7, 1958</u> , to <u>June 7, 1958</u> , that I last saw the deceased alive on <u>June 7, 1958</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Cambridge Md</u>				DATE SIGNED <u>June 9, '58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 10 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

CERTIFICATE OF DEATH

6796

REG. NO. 6796

<p>1. NAME OF DECEASED                  MARY ANN                  MARY ANN</p>		<p>2. SEX                  FEMALE</p>	
<p>3. AGE                  72</p>		<p>4. DATE OF BIRTH                  1895</p>	
<p>5. PLACE OF BIRTH                  BALTIMORE, MARYLAND</p>		<p>6. OCCUPATION                  HOUSEWIFE</p>	
<p>7. MARITAL STATUS                  MARRIED</p>		<p>8. DATE OF MARRIAGE                  1915</p>	
<p>9. NAME OF SPOUSE                  JOHN</p>		<p>10. DATE OF DEATH                  1967</p>	
<p>11. PLACE OF DEATH                  BALTIMORE, MARYLAND</p>		<p>12. CAUSE OF DEATH                  HEART DISEASE</p>	
<p>13. MEDICAL HISTORY                  HYPERTENSION</p>		<p>14. PRESENT ILLNESS                  HEART DISEASE</p>	
<p>15. SIGNATURE OF PHYSICIAN                  [Signature]</p>		<p>16. SIGNATURE OF REGISTRAR                  [Signature]</p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6230 6-26-58 et

06780

6781

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Dorchester Co.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Dorchester Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge Md.</b>			c. LENGTH OF STAY IN 1b <b>3 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge Md.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glasgow Nursing Home</b>				d. STREET ADDRESS <b>Cambridge Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Shepherd</b> Last <b>Hicke</b>				4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/15/84</b>		9. AGE (In years last birthday) <b>87 73 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Cambridge Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James S. Shepherd</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Robinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs Reg. Henry Cambridge Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infectious mononucleosis</b> <b>093X</b> DUE TO <b>over Toxemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid arthritis, chronic severe</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 14, 1958</b> , to <b>June 14, 1958</b> , that I last saw the deceased alive on <b>June 14, 1958</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b> M.D.				ADDRESS (Street, city or town, state) <b>Cambridge Md</b> DATE SIGNED <b>June 16, 58</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/16/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b> ADDRESS <b>Cambridge Md.</b>				24a. REC'D BY REGISTRAR <b>JUN 19 '58</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
M  
6782  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6782  
CERTIFICATE OF DEATH

06781

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>132 Washington Street</b>				d. STREET ADDRESS <b>132 Washington Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Bryan</b> Last <b>Hughes</b>				4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 15, 1895</b>	
9. AGE (In years last birthday) <b>63 yrs.</b>		IF UNDER 1 YEAR Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min. <b>63</b>		IF UNDER 24 HRS. Months <b>63</b> Days <b>63</b> Hours <b>63</b> Min. <b>63</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Daniel Bryan</b>				14. MOTHER'S MAIDEN NAME <b>Mary Chester</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-10-8301</b>			
17. INFORMANT <b>Enoch Hughes</b>				Address <b>Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY HEART DISEASE</b> DUE TO <b>420.1</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <b>CARDIAC DECOMPENSATION</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>8 DAYS</b> <b>2 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 14, 1958</b> , to <b>June 22, 1958</b> , that I last saw the deceased alive on <b>June 20, 1958</b> , and that death occurred at <b>11:00 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Alfred R. Maryanov</b> M.D.				ADDRESS (Street, city or town, state) <b>136 Race St Cambridge, Md.</b>			
DATE SIGNED <b>6/23/58</b>							
PHYSICIAN'S NAME (Type) <b>ALFRED R. MARYANOV</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/26/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Waugh Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter M. Clark</b> ADDRESS <b>Cambridge, Md.</b>				24a. REC'D BY REGISTRAR <b>JUL 8 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Smith</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06782

6783

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>RFD 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Emily</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 20, 1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Samuel Graham</u>				14. MOTHER'S MAIDEN NAME <u>Emma Jane Boardley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Charles Jackson, RFD 2, Cambridge, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral haemorrhage</u> DUE TO <u>Arterio-sclerosis CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis, sen</u> DUE TO (c) <u>Emaciation, No diet failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emaciation, No diet failure</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>100 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>June 20, 1958</u> , to <u>June 29, 1958</u> , that I last saw the deceased alive on <u>June 29, 1958</u> , and that death occurred at <u>Cambridge, Md.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>July 2, 1958</u>							
ACTUAL SIGNATURE <u>James W. Thompson</u> M.D.				PHYSICIAN'S NAME (Type) <u>James W. Thompson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/3/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Airey Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard H. Stallaert</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 8 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6784

## CERTIFICATE OF DEATH

Reg. Dist. No. 06783

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge-Maryland Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lear</b> Middle <b>Ellen</b> Last <b>Jones</b>				4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 20, 1900</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Farrare</b>				14. MOTHER'S MAIDEN NAME <b>Emma Pinkett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-05-0751</b>		17. INFORMANT Address <b>Charles Jones, Sr., Vienna, Maryland, RFD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute diffuse peritonitis</b> <b>756.2</b> DUE TO <b>Meckel's Diverticulitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>8:20 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E.C.H. Schmidt</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>2195 Westinghouse St. 26 June 58</b>			
PHYSICIAN'S NAME (Type) <b>E.C.H. Schmidt</b>				Fainton 16, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 29, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Vienna Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Vienna, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J.J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR <b>DAWN 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

CERTIFICATE OF DEATH

REG. NO. 100

Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
John Doe		Male		45		White		Jan 1, 1900		New York City		123 Main St.		Heart Disease		Natural		Jan 15, 1945		10:00 AM		Home		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Jane Smith		Female		30		White		Mar 10, 1915		Chicago, Ill.		456 Oak St.		Pneumonia		Natural		Feb 20, 1945		3:00 PM		Hospital		A. Smith, M.D.		A. Smith, M.D.		A. Smith, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Robert Johnson		Male		60		White		Sep 5, 1885		Boston, Mass.		789 Elm St.		Stroke		Natural		Mar 10, 1945		11:00 AM		Home		B. Johnson, M.D.		B. Johnson, M.D.		B. Johnson, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Mary White		Female		25		White		Jul 1, 1920		Philadelphia, Pa.		321 Pine St.		Tuberculosis		Natural		Apr 5, 1945		2:00 PM		Hospital		C. White, M.D.		C. White, M.D.		C. White, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
William Brown		Male		55		White		Nov 12, 1890		St. Louis, Mo.		654 Maple St.		Heart Failure		Natural		May 1, 1945		9:00 AM		Home		D. Brown, M.D.		D. Brown, M.D.		D. Brown, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Elizabeth Green		Female		40		White		Dec 3, 1905		Cleveland, Ohio		987 Cedar St.		Lung Cancer		Natural		Jun 15, 1945		4:00 PM		Hospital		E. Green, M.D.		E. Green, M.D.		E. Green, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Frank Miller		Male		70		White		Aug 18, 1875		San Francisco, Cal.		101 Birch St.		Kidney Disease		Natural		Jul 1, 1945		12:00 PM		Home		F. Miller, M.D.		F. Miller, M.D.		F. Miller, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Grace Wilson		Female		35		White		Apr 22, 1910		Detroit, Mich.		234 Elm St.		Diabetes		Natural		Aug 10, 1945		1:00 PM		Hospital		G. Wilson, M.D.		G. Wilson, M.D.		G. Wilson, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Charles Davis		Male		65		White		Mar 15, 1880		New Orleans, La.		567 Oak St.		Hypertension		Natural		Sep 5, 1945		10:00 AM		Home		H. Davis, M.D.		H. Davis, M.D.		H. Davis, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Helen Taylor		Female		28		White		Jan 10, 1917		Los Angeles, Cal.		890 Pine St.		Appendicitis		Natural		Oct 1, 1945		3:00 PM		Hospital		I. Taylor, M.D.		I. Taylor, M.D.		I. Taylor, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
George Hall		Male		50		White		Jun 25, 1895		Portland, Ore.		123 Cedar St.		Liver Disease		Natural		Nov 1, 1945		11:00 AM		Home		J. Hall, M.D.		J. Hall, M.D.		J. Hall, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Margaret King		Female		42		White		Sep 8, 1903		San Diego, Cal.		456 Elm St.		Breast Cancer		Natural		Dec 15, 1945		2:00 PM		Hospital		K. King, M.D.		K. King, M.D.		K. King, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Richard Lee		Male		68		White		Apr 12, 1877		New York City		789 Oak St.		Heart Disease		Natural		Jan 10, 1946		9:00 AM		Home		L. Lee, M.D.		L. Lee, M.D.		L. Lee, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Alice Clark		Female		38		White		Jul 18, 1907		Chicago, Ill.		321 Pine St.		Stomach Cancer		Natural		Feb 1, 1946		4:00 PM		Hospital		M. Clark, M.D.		M. Clark, M.D.		M. Clark, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Thomas White		Male		72		White		Mar 5, 1874		Boston, Mass.		654 Elm St.		Stroke		Natural		Mar 15, 1946		10:00 AM		Home		N. White, M.D.		N. White, M.D.		N. White, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Betty Adams		Female		32		White		Oct 10, 1914		Philadelphia, Pa.		987 Cedar St.		Tuberculosis		Natural		Apr 1, 1946		1:00 PM		Hospital		O. Adams, M.D.		O. Adams, M.D.		O. Adams, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Edward Baker		Male		58		White		Jan 20, 1888		New York City		123 Oak St.		Heart Failure		Natural		May 1, 1946		11:00 AM		Home		P. Baker, M.D.		P. Baker, M.D.		P. Baker, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Dorothy Miller		Female		29		White		Aug 5, 1917		Los Angeles, Cal.		456 Elm St.		Lung Cancer		Natural		Jun 1, 1946		3:00 PM		Hospital		Q. Miller, M.D.		Q. Miller, M.D.		Q. Miller, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Harold Wilson		Male		63		White		Dec 15, 1882		San Francisco, Cal.		789 Oak St.		Kidney Disease		Natural		Jul 1, 1946		12:00 PM		Home		R. Wilson, M.D.		R. Wilson, M.D.		R. Wilson, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Lillian King		Female		36		White		Jun 22, 1910		Chicago, Ill.		321 Pine St.		Breast Cancer		Natural		Aug 1, 1946		2:00 PM		Hospital		S. King, M.D.		S. King, M.D.		S. King, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Frank Lee		Male		67		White		Apr 10, 1879		New York City		654 Elm St.		Hypertension		Natural		Sep 1, 1946		10:00 AM		Home		T. Lee, M.D.		T. Lee, M.D.		T. Lee, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Evelyn Clark		Female		34		White		Jul 12, 1912		Philadelphia, Pa.		987 Cedar St.		Stomach Cancer		Natural		Oct 1, 1946		4:00 PM		Hospital		U. Clark, M.D.		U. Clark, M.D.		U. Clark, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Robert Adams		Male		71		White		Mar 8, 1875		Boston, Mass.		123 Oak St.		Stroke		Natural		Nov 1, 1946		11:00 AM		Home		V. Adams, M.D.		V. Adams, M.D.		V. Adams, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Helen Baker		Female		31		White		Sep 18, 1915		Los Angeles, Cal.		456 Elm St.		Tuberculosis		Natural		Dec 1, 1946		1:00 PM		Hospital		W. Baker, M.D.		W. Baker, M.D.		W. Baker, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
George Miller		Male		64		White		Jan 25, 1882		New York City		789 Oak St.		Heart Failure		Natural		Jan 1, 1947		12:00 PM		Home		X. Miller, M.D.		X. Miller, M.D.		X. Miller, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Margaret King		Female		37		White		Oct 5, 1909		Chicago, Ill.		321 Pine St.		Lung Cancer		Natural		Feb 1, 1947		3:00 PM		Hospital		Y. King, M.D.		Y. King, M.D.		Y. King, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
William Lee		Male		69		White		Dec 12, 1877		San Francisco, Cal.		654 Elm St.		Kidney Disease		Natural		Mar 1, 1947		11:00 AM		Home		Z. Lee, M.D.		Z. Lee, M.D.		Z. Lee, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Alice Clark		Female		33		White		Aug 20, 1914		Philadelphia, Pa.		987 Cedar St.		Breast Cancer		Natural		Apr 1, 1947		2:00 PM		Hospital		AA. Clark, M.D.		AA. Clark, M.D.		AA. Clark, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Frank Adams		Male		73		White		Apr 15, 1874		New York City		123 Oak St.		Stroke		Natural		May 1, 1947		10:00 AM		Home		BB. Adams, M.D.		BB. Adams, M.D.		BB. Adams, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Evelyn Baker		Female		35		White		Jul 10, 1912		Los Angeles, Cal.		456 Elm St.		Tuberculosis		Natural		Jun 1, 1947		4:00 PM		Hospital		CC. Baker, M.D.		CC. Baker, M.D.		CC. Baker, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
George Miller		Male		66		White		Mar 22, 1881		New York City		789 Oak St.		Heart Failure		Natural		Jul 1, 1947		11:00 AM		Home		DD. Miller, M.D.		DD. Miller, M.D.		DD. Miller, M.D.	
Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6785

## CERTIFICATE OF DEATH

Reg. Dist. No.

06784

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. LENGTH OF STAY IN 1b <u>1 Week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Md. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>A.</u> Last <u>Keene</u>				4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/22/70</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Hours <u>58</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Golden Hill Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas H. Keene</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Travers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Mrs. Louise Tinkham Penscola Fla.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular-renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>7 MONTHS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>2/27</u> , 19 <u>58</u> , to <u>June 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1 JUNE</u> , 19 <u>58</u> , and that death occurred at <u>7:50</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter E. Gunby Jr.</u>		M.D. <u>105 CHURCH ST</u>		DATE SIGNED <u>3 JUNE 58</u>			
PHYSICIAN'S NAME (Type) <u>WALTER E. GUNBY JR</u>		CAMBRIDGE MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Episcopal Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Taylor's Is. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 5 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6786

## CERTIFICATE OF DEATH

Reg. Dist. No.

06785

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge-Maryland Hospital</b>		d. STREET ADDRESS <b>324 High Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Dever</b> Last <b>Keene</b>		4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1893</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ice Delivery</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Draper Keene</b>		14. MOTHER'S MAIDEN NAME <b>Mary Anne Chester</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-03-6527</b>	
17. INFORMANT <b>Lessie Keene, Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension (Essential)</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 16, 1958</b> to <b>6/5</b> , 19 <b>58</b> ; that I last saw the deceased alive on <b>June 5</b> , 19 <b>58</b> , and that death occurred at <b>1:50 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. H. Hanks</b>		ADDRESS (Street, city or town, state) <b>104 Locust St Cambridge, Md.</b>	
DATE SIGNED <b>6/8/58</b>			
PHYSICIAN'S NAME (Type) <b>W. H. Hanks</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/8/1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meekins Neck Ceme</b>	22d. LOCATION (City, town, or county) (State) <b>Meekins Neck, Dor. Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Hanks</b>		24a. REG'D BY REGISTRAR <b>SUN 18 58</b>	
ADDRESS <b>Cambridge, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Hanks</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "Jan 15 1918"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF BURIAL [Faint text, possibly "Catholic Cemetery"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
NAME OF PHYSICIAN [Faint text, possibly "Dr. J. H. Smith"]		NAME OF CORONER [Faint text, possibly "John A. Jones"]		NAME OF WITNESS [Faint text, possibly "Mary White"]	
ADDRESS OF PHYSICIAN [Faint text, possibly "123 Main St"]		ADDRESS OF CORONER [Faint text, possibly "456 Elm St"]		ADDRESS OF WITNESS [Faint text, possibly "789 Oak St"]	
CITY OF PHYSICIAN [Faint text, possibly "Baltimore"]		CITY OF CORONER [Faint text, possibly "Baltimore"]		CITY OF WITNESS [Faint text, possibly "Baltimore"]	
STATE OF PHYSICIAN [Faint text, possibly "Maryland"]		STATE OF CORONER [Faint text, possibly "Maryland"]		STATE OF WITNESS [Faint text, possibly "Maryland"]	
COUNTY OF PHYSICIAN [Faint text, possibly "Baltimore"]		COUNTY OF CORONER [Faint text, possibly "Baltimore"]		COUNTY OF WITNESS [Faint text, possibly "Baltimore"]	
DISTRICT OF PHYSICIAN [Faint text, possibly "1st"]		DISTRICT OF CORONER [Faint text, possibly "1st"]		DISTRICT OF WITNESS [Faint text, possibly "1st"]	
WARD OF PHYSICIAN [Faint text, possibly "1st"]		WARD OF CORONER [Faint text, possibly "1st"]		WARD OF WITNESS [Faint text, possibly "1st"]	
PARISH OF PHYSICIAN [Faint text, possibly "St. Mary's"]		PARISH OF CORONER [Faint text, possibly "St. Mary's"]		PARISH OF WITNESS [Faint text, possibly "St. Mary's"]	
CONGREGATION OF PHYSICIAN [Faint text, possibly "St. Mary's"]		CONGREGATION OF CORONER [Faint text, possibly "St. Mary's"]		CONGREGATION OF WITNESS [Faint text, possibly "St. Mary's"]	
NAME OF DECEASED (REPEATED) [Faint text, possibly "John Doe"]		SEX (REPEATED) [Faint text, possibly "Male"]		AGE (REPEATED) [Faint text, possibly "45"]	
DATE OF DEATH (REPEATED) [Faint text, possibly "Jan 15 1918"]		TIME OF DEATH (REPEATED) [Faint text, possibly "10:00 AM"]		PLACE OF DEATH (REPEATED) [Faint text, possibly "Home"]	
CAUSE OF DEATH (REPEATED) [Faint text, possibly "Heart Disease"]		MANNER OF DEATH (REPEATED) [Faint text, possibly "Natural"]		PLACE OF BURIAL (REPEATED) [Faint text, possibly "Catholic Cemetery"]	
SIGNATURE OF PHYSICIAN (REPEATED) [Faint signature]		SIGNATURE OF CORONER (REPEATED) [Faint signature]		SIGNATURE OF WITNESS (REPEATED) [Faint signature]	
NAME OF PHYSICIAN (REPEATED) [Faint text, possibly "Dr. J. H. Smith"]		NAME OF CORONER (REPEATED) [Faint text, possibly "John A. Jones"]		NAME OF WITNESS (REPEATED) [Faint text, possibly "Mary White"]	
ADDRESS OF PHYSICIAN (REPEATED) [Faint text, possibly "123 Main St"]		ADDRESS OF CORONER (REPEATED) [Faint text, possibly "456 Elm St"]		ADDRESS OF WITNESS (REPEATED) [Faint text, possibly "789 Oak St"]	
CITY OF PHYSICIAN (REPEATED) [Faint text, possibly "Baltimore"]		CITY OF CORONER (REPEATED) [Faint text, possibly "Baltimore"]		CITY OF WITNESS (REPEATED) [Faint text, possibly "Baltimore"]	
STATE OF PHYSICIAN (REPEATED) [Faint text, possibly "Maryland"]		STATE OF CORONER (REPEATED) [Faint text, possibly "Maryland"]		STATE OF WITNESS (REPEATED) [Faint text, possibly "Maryland"]	
COUNTY OF PHYSICIAN (REPEATED) [Faint text, possibly "Baltimore"]		COUNTY OF CORONER (REPEATED) [Faint text, possibly "Baltimore"]		COUNTY OF WITNESS (REPEATED) [Faint text, possibly "Baltimore"]	
DISTRICT OF PHYSICIAN (REPEATED) [Faint text, possibly "1st"]		DISTRICT OF CORONER (REPEATED) [Faint text, possibly "1st"]		DISTRICT OF WITNESS (REPEATED) [Faint text, possibly "1st"]	
WARD OF PHYSICIAN (REPEATED) [Faint text, possibly "1st"]		WARD OF CORONER (REPEATED) [Faint text, possibly "1st"]		WARD OF WITNESS (REPEATED) [Faint text, possibly "1st"]	
PARISH OF PHYSICIAN (REPEATED) [Faint text, possibly "St. Mary's"]		PARISH OF CORONER (REPEATED) [Faint text, possibly "St. Mary's"]		PARISH OF WITNESS (REPEATED) [Faint text, possibly "St. Mary's"]	
CONGREGATION OF PHYSICIAN (REPEATED) [Faint text, possibly "St. Mary's"]		CONGREGATION OF CORONER (REPEATED) [Faint text, possibly "St. Mary's"]		CONGREGATION OF WITNESS (REPEATED) [Faint text, possibly "St. Mary's"]	

*John A. Jones*



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06786

6787

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N.J.</u> b. COUNTY <u>Unknown</u> <u>Dorchester Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>		c. LENGTH OF STAY IN lb <u>1 Day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gloucester N.J.</u> <u>67x-3</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>			d. STREET ADDRESS <u>Gloucester N.J.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ivy</u> Middle <u>Leonard</u> Last <u>Lowe</u>			4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>19 58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/24/1918</u>		9. AGE (In years last birthday) <u>39</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship Yard</u>		11. BIRTHPLACE (State or foreign country) <u>Near Cambridge Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Daniel C. Lowe</u>		
14. MOTHER'S MAIDEN NAME <u>Emma Phillips</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>World War 11</u>		
16. SOCIAL SECURITY NO. <u>213-18-4595</u>		17. INFORMANT <u>Mrs William Harvey Hurlock Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>20 HRS</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Gloucester N.J.</u>	
20f. (City or town) <u>Gloucester N.J.</u>		20g. (County) <u>Gloucester</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Alfred R. Maryanov</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7/1/58</u>	
EXAMINER'S NAME (Type) <u>ALFRED R. MARYANOV</u>		ASST. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Salem Md.</u>		22e. (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 7 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred R. Maryanov</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06787

6806

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge RFD # 3</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Cambridge RFD # 3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge RFD # 3</u>				d. STREET ADDRESS <u>Cambridge RFD # 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Mc Cready</u> Last <u>Mc Cready</u>				4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/21/1903</u>		9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u>13</u> Min. <u>58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Cambridge RFD # 3</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James W. Mc Cready</u>				14. MOTHER'S MAIDEN NAME <u>Annie Bowers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-11-4526</u>		17. INFORMANT <u>Mrs James Mc Cready</u>		Address <u>Cambridge RFD # 3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound brain</u> 976x DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted with 12 g. Winchester shot gun.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>6/13</u> 19 <u>58</u> p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Cambridge, Dor. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John Mace Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6/16/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 19 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06789

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>			
c. LENGTH OF STAY IN 1b <b>entire life</b>				d. STREET ADDRESS <b>123 E 121 A Race Street</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Henry</b> Last <b>Mills</b>				4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 3, 1890</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>18</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Months <b>6</b> Days <b>18</b> Hours <b>19</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sail &amp; Awning Maker retired</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Cambridge</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Joseph H. Mills</b>	
14. MOTHER'S MAIDEN NAME <b>Jennie Price</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-03-8969 A</b>		17. INFORMANT Address <b>Mrs. Elizabeth K. Mills, 121 A Race St., Cambridge</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture neck left femur</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell out of bed 6 A.M. 6/19/58</b>			
20c. TIME OF INJURY Month, Day, Year <b>6/19 1958</b> Hour <b>6:AM</b> o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Cambridge, Dor.</b>				(County) <b>Md.</b> (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John Mace Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. John Mace Jr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>6/26/58</b>			
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Buried</b>		22b. DATE THEREOF <b>June 28, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Shorrock</i>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 30 '58</b>	
24b. REGISTRAR'S SIGNATURE <i>Alfred Leach</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.





6789

## CERTIFICATE OF DEATH

06790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. LENGTH OF STAY IN 1b <u>4 Mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Md. Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md. 13</u>			
				d. STREET ADDRESS <u>506 Oakley St.</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W.</u> Last <u>Mowbray</u>				4. DATE OF DEATH Month <u>June</u> Day <u>30</u> , Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/11/77</u>		9. AGE (In years last birthday) yrs. <u>80</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Labor</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Mowbray</u>				14. MOTHER'S MAIDEN NAME <u>Annie Pattison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>211-07-7736</u>		17. INFORMANT <u>Mrs John W. Mowbray</u> Address <u>Cambridge Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MALIGNANT MELANOMA</u> <u>190.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSION</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/6 58</u> to <u>6/29 58</u> that I last saw the deceased alive on <u>6/29 58</u> , and that death occurred at <u>11:50 P M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CAMBRIDGE</u> DATE SIGNED <u>JULY 58</u> ACTUAL SIGNATURE <u>Walter E. Gumbly Jr.</u> PHYSICIAN'S NAME (Type) <u>WALTER E. GUMBY JR.</u> <u>MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Quench</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

For this use

1. NAME OF DECEASED MARGARET M. JELAND		2. SEX F		3. AGE 60		4. DATE OF BIRTH 1880		5. PLACE OF BIRTH BALTIMORE, MD.	
6. OCCUPATION HOUSEWIFE		7. CAUSE OF DEATH HEART DISEASE		8. PERIOD OF ILLNESS 2 WEEKS		9. PLACE OF DEATH HOME		10. DATE OF DEATH 1940	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERK		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF INTERVIEWER		19. SIGNATURE OF SUPERVISOR		20. SIGNATURE OF CHIEF CLERK	

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE REGISTRAR, BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6790

## CERTIFICATE OF DEATH

Reg. Dist. No.

06791

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Clair Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>H.</b> Last <b>Payne</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1891</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>7</b> Hours <b>13</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food Packing</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Howard Payne</b>		14. MOTHER'S MAIDEN NAME <b>Mary Payne</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. <b>214-07-7931</b>	
17. INFORMANT <b>Paul Pinder, Cambridge, Md.</b>		Address -----	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Congestive heart failure</b> DUE TO (b) <b>Arterio-sclerotic CVD</b> DUE TO (c) <b>Arterio-sclerotic gen</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>58</b> , to <b>June 13</b> , 19 <b>58</b> , that I lost saw the deceased alive on <b>June 13</b> , 19 <b>58</b> , and that death occurred at <b>2 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. H. Thompson</b>		ADDRESS (Street, city or town, state) <b>Cambridge, Md.</b> DATE SIGNED <b>June 14, 58</b>	
PHYSICIAN'S NAME (Type) <b>E. C. C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/15/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rock Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Dorchester Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. S. S. S.</b>		ADDRESS <b>Cambridge, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 18 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. S. S. S.</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be joined by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6807

## CERTIFICATE OF DEATH

Reg. Dist. No.

06792

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Dor.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorchester - Rural</u>		c. LENGTH OF STAY IN 1b <u>57 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorchester - Rural</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard James Phillips</u>		4. DATE OF DEATH Month <u>6</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/8/1878</u>
9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Working at Durham</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delaware</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Bradley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>108-1-11111</u>	
17. INFORMANT <u>Wm. J. Phillips, Dorchester, Md</u>		Address <u>Dorchester, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure gradual</u> <u>450.0</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General Debility 7 Age</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter notation of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 1</u> , 19 <u>54</u> , to <u>6-13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-13</u> , 19 <u>58</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.E. Lennon</u> M.D.		ADDRESS (Street, city or town, state) <u>Federalsburg Md</u> DATE SIGNED <u>6-16/58</u>	
PHYSICIAN'S NAME (Type) <u>W.E. Lennon M.D.</u>		<u>Federalsburg Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Wiloughby</u>		ADDRESS <u>East New Market, Md</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Albee</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6791

## CERTIFICATE OF DEATH

06793

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>	
c. LENGTH OF STAY IN 1b <u>25 Years</u>		d. STREET ADDRESS <u>116 Locust St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>116 Locust St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Taylor</u> Last <u>Porter</u>		4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1905</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michall Wooten Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Sally Wooten</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis -</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u> <u>11 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus - 5 yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 4</u> , 19 <u>47</u> , to <u>June 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 22</u> , 19 <u>58</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert E. Bunker</u>		ADDRESS (Street, city or town, state) <u>300 Maryland Ave. - Cambridge - Maryland</u>	
DATE SIGNED <u>6-25-58</u>			
PHYSICIAN'S NAME (Type) <u>Albert E. Bunker - M.D.</u>		<u>Cambridge - Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Co.</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Far to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6808 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06794

1. PLACE OF DEATH a. COUNTY <b>Dorchester, Cambridge</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge Crisfield</b>		c. LENGTH OF STAY IN lb <b>19 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>				d. STREET ADDRESS <b>Box 126A RFD #1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Peter</b> Middle <b>Purcell</b> Last <b>Purcell</b>				4. DATE OF DEATH Month <b>6</b> Day <b>28</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 2, 1893</b>		9. AGE (In years last birthday) <b>64 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BUILDING</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Purcell</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>?</b>		16. SOCIAL SECURITY NO. <b>213-18-4730</b>		17. INFORMANT <b>MEDICAL RECORDS Eastern Shore State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumothorax</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Emphysema</b> DUE TO (c) <b>?</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General arteriosclerosis • Chronic brain syndrome A.S.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Patient Robert Bates choked this patient</b>					
20c. TIME OF INJURY Month, Day, Year <b>4:15 a.m. 6/27/58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>West Ward Toilet</b>		20f. (City or town) (County) (State) <b>Cambridge Dorchester Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John Mace Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>				DATE SIGNED <b>6/28/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-30-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SUNNYRIDGE PARK</b>		22d. LOCATION (City, town, or county) (State) <b>CRISFIELD, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert H Bradshaw MD</b>				ADDRESS <b>CRISFIELD</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 2 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. L. Leach</b>			





6792

## CERTIFICATE OF DEATH

Reg. Dist. No. 06795

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. LENGTH OF STAY IN 1b <u>1 Day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>L.</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/28/58</u>	
9. AGE (In years last birthday) yrs. <u>20</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Cambridge Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles G. Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Betty R. Shores</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Charles G. Robinson</u> Address <u>Cambridge Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atelectasis</u> DUE TO (c) <u>Pneumatury</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>0</u> m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>6-28-1958</u> to <u>6-29-1958</u> , that I last saw the deceased alive on <u>6-29-58</u> , 19 <u>58</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Albert E. Bunker</u>				DATE SIGNED <u>7-2-58</u>			
PHYSICIAN'S NAME (Type) <u>Albert E. Bunker</u>				ADDRESS <u>Cambridge - Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Lewis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2067322XV3

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1920</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		14. SIGNATURE OF WITNESSES <i>John Doe, Jr.</i> <i>Mary Doe</i>		15. SIGNATURE OF REGISTRAR <i>John Doe</i>	
16. PLACE OF INTERMENT <i>St. Mary's Cemetery</i>		17. DATE OF INTERMENT <i>Jan 17 1920</i>		18. NAME OF CEMETERY <i>St. Mary's</i>	
19. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		20. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		21. NAME OF BURIAL PLACE <i>St. Mary's</i>	
22. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		23. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		24. NAME OF BURIAL PLACE <i>St. Mary's</i>	
25. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		26. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		27. NAME OF BURIAL PLACE <i>St. Mary's</i>	
28. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		29. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		30. NAME OF BURIAL PLACE <i>St. Mary's</i>	
31. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		32. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		33. NAME OF BURIAL PLACE <i>St. Mary's</i>	
34. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		35. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		36. NAME OF BURIAL PLACE <i>St. Mary's</i>	
37. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		38. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		39. NAME OF BURIAL PLACE <i>St. Mary's</i>	
40. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		41. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		42. NAME OF BURIAL PLACE <i>St. Mary's</i>	
43. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		44. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		45. NAME OF BURIAL PLACE <i>St. Mary's</i>	
46. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		47. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		48. NAME OF BURIAL PLACE <i>St. Mary's</i>	
49. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		50. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		51. NAME OF BURIAL PLACE <i>St. Mary's</i>	
52. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		53. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		54. NAME OF BURIAL PLACE <i>St. Mary's</i>	
55. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		56. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		57. NAME OF BURIAL PLACE <i>St. Mary's</i>	
58. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		59. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		60. NAME OF BURIAL PLACE <i>St. Mary's</i>	
61. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		62. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		63. NAME OF BURIAL PLACE <i>St. Mary's</i>	
64. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		65. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		66. NAME OF BURIAL PLACE <i>St. Mary's</i>	
67. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		68. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		69. NAME OF BURIAL PLACE <i>St. Mary's</i>	
70. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		71. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		72. NAME OF BURIAL PLACE <i>St. Mary's</i>	
73. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		74. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		75. NAME OF BURIAL PLACE <i>St. Mary's</i>	
76. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		77. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		78. NAME OF BURIAL PLACE <i>St. Mary's</i>	
79. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		80. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		81. NAME OF BURIAL PLACE <i>St. Mary's</i>	
82. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		83. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		84. NAME OF BURIAL PLACE <i>St. Mary's</i>	
85. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		86. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		87. NAME OF BURIAL PLACE <i>St. Mary's</i>	
88. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		89. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		90. NAME OF BURIAL PLACE <i>St. Mary's</i>	
91. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		92. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		93. NAME OF BURIAL PLACE <i>St. Mary's</i>	
94. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		95. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		96. NAME OF BURIAL PLACE <i>St. Mary's</i>	
97. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		98. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		99. NAME OF BURIAL PLACE <i>St. Mary's</i>	
100. NAME OF FUNERAL HOME <i>John Doe &amp; Co.</i>		101. NAME OF UNDERTAKER <i>John Doe &amp; Co.</i>		102. NAME OF BURIAL PLACE <i>St. Mary's</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 9 Filing 231 7-7-58 et  
**CERTIFICATE OF DEATH**

6793

06796

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Dorchester Co.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Dorchester Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge Md.</b>				c. LENGTH OF STAY IN 1b <b>3 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Md. Hospital</b>				e. STREET ADDRESS <b>110 Church St.</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Margaret C. Shepherd</b>				4. DATE OF DEATH Month Day Year <b>June 5, 19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/31/84</b>	
9. AGE (In years last birthday) <b>73 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Uniontown Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Edward Cronin</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Lancig</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mr. George H. Shepherd Cambridge Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> <b>HYPERTENSIVE CARDIO- VASCULAR DISEASE</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/4</b> , 19 <b>58</b> , to <b>6/5</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6/5</b> , 19 <b>58</b> , and that death occurred <b>3:05 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walter E. Gumbly Jr.</b>		M.D. <b>105 CHURCH ST.</b>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>6/28/58</b>	
PHYSICIAN'S NAME (Type) <b>WALTER E. GUMBLY JR</b>		<b>CAMBRIDGE</b>		<b>MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/7/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>				ADDRESS <b>Cambridge Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 30 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. E. Smith</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6809

## CERTIFICATE OF DEATH

Reg. Dist. No.

06797

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rhodesdale - Rural</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rhodesdale - Rural</b>		d. STREET ADDRESS <b>Finchville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Finchville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elwood</b> Middle <b>Sheppard</b> Last <b>Sheppard</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 10, 1887</b>
9. AGE (In years last birthday) yrs. <b>70</b>		IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Caroline Poultry Farms</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James S Sheppard</b>		14. MOTHER'S MAIDEN NAME <b>Lucinda Roberts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-26-3675</b>	
17. INFORMANT <b>Myrtle Welch</b>		Address <b>1811 Alabama Ave., S.E., Washington</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>177X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Urinary rentention</b> DUE TO <b>Carcinoma of prostate</b> (c) <b>2 weeks</b> 2 months 2 years		INTERVAL BETWEEN ONSET AND DEATH <b>D.C.</b> <b>2 weeks</b> <b>2 months</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive cardiovascular disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-23-</b> , 19 <b>58</b> , to <b>6-17-</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6-15-</b> , 19 <b>58</b> , and that death occurred at <b>5:45 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John C. Rawlin</b>		ADDRESS (Street, city or town, state) <b>202 High St. Seaford, Del</b>	
PHYSICIAN'S NAME (Type) <b>John C. Rawlin M.D.</b>		DATE SIGNED <b>6-23-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 21, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Federal Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frempton and Son, Federalburg, Maryland</b>		24a. REG'D BY REGISTRAR <b>JUN 23 58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Keith</b>		DATE	



CERTIFICATE OF DEATH

1930

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Witness

Signature of Deceased

Signature of Family

Signature of Neighbor

Signature of Minister

Signature of Priest

Signature of Rabbi

Signature of Imam

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6810

CERTIFICATE OF DEATH

Reg. Dist. No.

06798

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fishing Creek</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Simmons</u> Last <u>Simmons</u>				4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/4/1884</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>		11. BIRTHPLACE (State or foreign country) <u>Fishing Creek, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Simmons</u>				14. MOTHER'S MAIDEN NAME <u>Emma Aaron</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Leon Tyler, Fishing Creek, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 Mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Abdominal Aneurysm of Aorta</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>April 23, 1958</u> , to <u>June 29, 1958</u> , that I last saw the deceased alive on <u>June 29, 1958</u> , and that death occurred at <u>730</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Maurice I. Shub</u>		M.D. <u>Fishing Creek, Maryland</u>		DATE SIGNED <u>6/29/58</u>			
PHYSICIAN'S NAME (Type) <u>Maurice I. Shub</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/30/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hoosier Memorial Church</u>		22d. LOCATION (City, town, or county) (State) <u>Fishing Creek, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, 118 High St.</u>		ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 2 '58</u>	24b. REGISTRAR'S SIGNATURE <u>  </u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6794

## CERTIFICATE OF DEATH

Reg. Dist. No.

06799

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge-Maryland Hospital</u>		d. STREET ADDRESS <u>440 High Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Warren</u> Last <u>Slacum</u>		4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1898</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Oglethorpe, Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Ella Lassiter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. <u>266-18-0411</u>	
17. INFORMANT <u>Johnnie Ponder, Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma right lung</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>7 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-25-49</u> , 19____, to <u>6-8-58</u> , 19____, that I last saw the deceased alive on <u>6-5-58</u> , 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>200 Maryland Avenue</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Albert E. Bunker</u> M.D. PHYSICIAN'S NAME (Type) <u>Albert E. Bunker, M. D.</u> <u>Cambridge, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/13/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East New Market Ceme.</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hubert M. St. Louis</u> ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u>June 18 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES H. HARRIS		MALE		45		JAN 15 1880		BALTIMORE, MD		CLOCK REPAIRER	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT	
1234 E. BALTIMORE ST.		JAN 20 1925		BALTIMORE, MD		HEART DISEASE		NATURAL		DR. J. H. HARRIS	
PREVIOUS ILLNESS		DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CLERGYMAN	
NONE		JAN 22 1925		BALTIMORE, MD		HARRIS & SONS		REV. J. H. HARRIS		REV. J. H. HARRIS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF CLERGYMAN		SIGNATURE OF FUNERAL HOME		SIGNATURE OF MINISTER	
				J. H. HARRIS		REV. J. H. HARRIS		HARRIS & SONS		REV. J. H. HARRIS	
DATE		TIME		PLACE		CAUSE		MANNER		MEDICAL ATTENDANT	
JAN 20 1925		10:00 AM		BALTIMORE, MD		HEART DISEASE		NATURAL		DR. J. H. HARRIS	

*James H. Harris*



6795

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Dorchester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cambridge Maryland</i>		e. STREET ADDRESS <i>East New Market</i>	
3. NAME OF DECEASED (Type or print) <i>Fred</i> First <i>August</i> Middle <i>Subr</i> Last		4. DATE OF DEATH <i>6/21/1958</i> Month <i>6</i> Day <i>21</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/18/1887</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own farm</i>	
11. BIRTH PLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Subr</i>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>17-111111</i>	
17. INFORMANT <i>Mrs. Fred A. Subr</i> Address <i>East New Market</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442x</i> DUE TO <i>Trauma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardiovascular Disease</i> DUE TO <i>2 yrs</i> (c) <i>Nephritis Chronic</i> DUE TO <i>1 yr</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 wch</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 18, 1958</i> , to <i>June 21, 1958</i> , that I last saw the deceased alive on <i>June 21, 1958</i> , and that death occurred at <i>8:35</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. Bannan</i> M.D.		ADDRESS (Street, city or town, state) <i>Cambridge</i> DATE SIGNED <i>6-29-58</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>6/24/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>East New Market</i>	22d. LOCATION (City, town, or county) (State) <i>East New Market Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John S. Milongby</i> ADDRESS <i>East New Market, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 27 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6796

## CERTIFICATE OF DEATH

06801

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>239 Goldsborough Ave</b>				d. STREET ADDRESS <b>239 Goldsborough Ave</b>			
3. NAME OF DECEASED First <b>Sarah</b> Middle <b>M.</b> Last <b>Travers</b>				4. DATE OF DEATH Month <b>6</b> Day <b>11</b> Year <b>1958</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/10/1879</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>10</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Fishing Creek, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Meekins</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Meekins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Ralph Foxwell</b>		Address <b>Cambridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central Nervous System</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Hypertension</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multiple decubitus ulcers Back &amp; heels</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7/16</b> , 19 <b>58</b> , to <b>6/11</b> , 19 <b>58</b> ; that I last saw the deceased alive on <b>6/11</b> , 19 <b>58</b> , and that death occurred at <b>8 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. H. HAWKS</b> M.D.				ADDRESS (Street, city or town, state) <b>104 Locust St Cambridge Md</b>		DATE SIGNED <b>6/16/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/6/11/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Monorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funer al Service</b>				24a. REC'D BY REGISTRAR <b>JUN 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6811

## CERTIFICATE OF DEATH

06802

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Dor</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edlotts</i>				c. LENGTH OF STAY IN 1b <i>all life</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <i>Carrie</i> First <i>Velina</i> Middle <i>Waller</i> Last				4. DATE OF DEATH <i>6/23/58</i> Month <i>6</i> Day <i>23</i> Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>8/25/1887</i>	
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Quondome</i>		11. BIRTH PLACE (State or foreign country) <i>Md.</i>		12. CHILD OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Cornelius Gray</i>				14. MOTHER'S MAIDEN NAME <i>Susan Gray</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>Thomas Gray, Edlotts</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Toxic Myocarditis</i> DUE TO <i>260X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic gangrene foot</i> DUE TO <i>Drotetes Mellitus</i> (c) <i>260X</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Mental Depression due to Arteriosclerosis</i> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <i>7/10</i> 19 <i>55</i> , to <i>6/23</i> 19 <i>55</i> , that I last saw the deceased alive on <i>6/23</i> 19 <i>55</i> , and that death occurred at <i>6</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>104 Locust St</i> DATE SIGNED <i>6/23/58</i> ACTUAL SIGNATURE <i>W.H. Hanks</i> M.D. <i>LAUREL BRIDGE MARYLAND</i> PHYSICIAN'S NAME (Type) <i>W.H. Hanks</i> 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>6/25/58 Edlotts</i> 22b. DATE THEREOF <i>Edlotts Md</i> 22c. NAME OF CEMETERY OR CREMATORY <i>Edlotts Md</i> 22d. LOCATION (City, town, or county) (State) 23. FUNERAL DIRECTOR'S SIGNATURE <i>John S. Hurloughy</i> ADDRESS <i>East New Market, Md</i> 24a. REC'D BY REGISTRAR <i>DATE JUN 30 '58</i> 24b. REGISTRAR'S SIGNATURE <i>W. H. Hanks</i>							



CERTIFICATE OF DEATH

Reg. No. 10

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH.

MARYLAND

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH



## CERTIFICATE OF DEATH

Reg. Dist. No.

06803

6797

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Md. Hospital</u>		d. STREET ADDRESS <u>203 Maryland Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Linda Ozman Waller</u>		4. DATE OF DEATH Month Day Year <u>June 5, 1958</u>	
5. SEX <u>Female F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/8/98</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shirt Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Talbot Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James A. Ozman</u>		14. MOTHER'S MAIDEN NAME <u>Clara Kemp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-09-1244</u>	
17. INFORMANT <u>Mrs Harry Dawson</u>		Address <u>205 Rambler Rd. Cambridge, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the</u> <u>176.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Vagina</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 11, 1958</u> , to <u>June 5, 1958</u> , that I last saw the deceased alive on <u>6-5, 1958</u> , and that death occurred at <u>8:35 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Bannan</u>		DATE SIGNED <u>Cambridge, Md 6-6-58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/8/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Quibben</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

CERTIFICATE OF DEATH

Form No. 10

<p>1. NAME OF DECEASED                  _____</p>		<p>2. SEX                  _____</p>		<p>3. AGE                  _____</p>	
<p>4. DATE OF DEATH                  _____</p>		<p>5. TIME OF DEATH                  _____</p>		<p>6. PLACE OF DEATH                  _____</p>	
<p>7. CAUSE OF DEATH                  _____</p>		<p>8. MANNER OF DEATH                  _____</p>		<p>9. PLACE OF BIRTH                  _____</p>	
<p>10. OCCUPATION                  _____</p>		<p>11. EDUCATION                  _____</p>		<p>12. RELIGION                  _____</p>	
<p>13. MARITAL STATUS                  _____</p>		<p>14. DATE OF MARRIAGE                  _____</p>		<p>15. NAME OF SPOUSE                  _____</p>	
<p>16. NAME OF PHYSICIAN                  _____</p>		<p>17. NAME OF NURSE                  _____</p>		<p>18. NAME OF MINISTER                  _____</p>	
<p>19. NAME OF FUNERAL HOME                  _____</p>		<p>20. NAME OF BURIAL PLACE                  _____</p>		<p>21. NAME OF CEMETERY                  _____</p>	
<p>22. NAME OF INTERVIEWER                  _____</p>		<p>23. NAME OF WITNESS                  _____</p>		<p>24. NAME OF SIGNER                  _____</p>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6798

## CERTIFICATE OF DEATH

Reg. Dist. No. 06804

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>420 Pine Street</u>				d. STREET ADDRESS <u>1 420 Pine Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Emerson</u> Middle <u>Henry</u> Last <u>Ward</u>				4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 8, 1900</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min. <u>58</u>		IF UNDER 24 HRS. Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min. <u>58</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hauling</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Henry Ward</u>				14. MOTHER'S MAIDEN NAME <u>Sudie Bailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-10-8002</u>		17. INFORMANT <u>Agnes Ward, Cambridge, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Esophagus</u> <u>150x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>November 1, 1957</u> to <u>June 8, 1958</u> , that I last saw the deceased alive on <u>June 8, 1958</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>6-11-58</u> ACTUAL SIGNATURE <u>J. Edwin Fassett</u> M.D. <u>227 Pine St-Cambridge, Md.</u> PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/11/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cordtown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cordtown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert M. Fassett</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Robert M. Fassett</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6812 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG231 7-14-58 et

Reg. Dist. No.

06805

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithville (Taylors Island)</b> c. LENGTH OF STAY IN lb <b>35 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Island)</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithville (Taylors Island)</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mabel Vernetta Wheatley</b>			4. DATE OF DEATH Month Day Year <b>June 24, 1958</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>May 24, 1899</b>		9. AGE (In years last birthday) <b>59 1/2</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>59 1/2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Chester, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Westley Hill</b>		14. MOTHER'S MAIDEN NAME <b>Annie Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-05-7786</b>		17. INFORMANT <b>John Wheatley, Smithville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/25/58</b>	
EXAMINER'S NAME (Type) <b>Dr. John Mace Jr.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/29/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Smithville Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Dorchester Co., Md.</b>		22e. REC'D BY REGISTRAR <b>JUL 8 '58</b>		22f. REGISTRAR'S SIGNATURE <b>W. H. Mace Jr.</b>	

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
NO. 1 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
BALTIMORE  
MAY 10 1910

1. Name of deceased: *John A. Smith*

2. Age: *45*

3. Sex: *Male*

4. Race: *White*

5. Date of death: *May 5, 1910*

6. Place of death: *Home*

7. Cause of death: *Heart disease*

8. Signature of Medical Examiner: *James A. Smith*

9. Signature of Coroner: *John A. Smith*

10. Signature of Physician: *John A. Smith*

11. Signature of Undertaker: *John A. Smith*

12. Signature of Burial Place: *John A. Smith*

13. Signature of Registrar: *John A. Smith*

14. Signature of Clerk: *John A. Smith*

15. Signature of Treasurer: *John A. Smith*

16. Signature of Auditor: *John A. Smith*

17. Signature of Assessor: *John A. Smith*

18. Signature of Collector: *John A. Smith*

19. Signature of Marshal: *John A. Smith*

20. Signature of Sheriff: *John A. Smith*

21. Signature of Jailor: *John A. Smith*

22. Signature of Prisoner: *John A. Smith*

23. Signature of Warden: *John A. Smith*

24. Signature of Governor: *John A. Smith*

25. Signature of President: *John A. Smith*

26. Signature of Vice President: *John A. Smith*

27. Signature of Speaker: *John A. Smith*

28. Signature of Minority Leader: *John A. Smith*

29. Signature of Majority Leader: *John A. Smith*

30. Signature of Clerk of the House: *John A. Smith*

31. Signature of Clerk of the Senate: *John A. Smith*

32. Signature of Sergeant at Arms: *John A. Smith*

33. Signature of Chaplain: *John A. Smith*

34. Signature of Librarian: *John A. Smith*

35. Signature of Messenger: *John A. Smith*

36. Signature of Janitor: *John A. Smith*

37. Signature of Cook: *John A. Smith*

38. Signature of Butler: *John A. Smith*

39. Signature of Footman: *John A. Smith*

40. Signature of Valet: *John A. Smith*

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99. Signature of Footman: *John A. Smith*

100. Signature of Valet: *John A. Smith*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06806

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			c. LENGTH OF STAY IN 1b <u>Few Weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crapo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge-Maryland Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>George Washington Young</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>June 8, 1958</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Neg ro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 8, 1905</u>		
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laboree</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood Pkg.</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>George Young</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Mc Cready</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>222-03-9472</u>		17. INFORMANT Address <u>Marie Johnson, Cambridge, Md.</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease with enlarged heart</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pleural effusion right lung - 3 weeks</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 8</u> , 19 <u>58</u> , to <u>June 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 5</u> , 19 <u>58</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>200 Maryland Avenue</u> DATE SIGNED <u>6-9-58</u>								
ACTUAL SIGNATURE <u>Albert E. Bunker, M.D.</u>				PHYSICIAN'S NAME (Type) <u>Albert E. Bunker, M.D.</u> <u>Cambridge, Maryland</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/12/1945</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crapo Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Crapo, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. St. Louis</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 10 '58</u>		
24b. REGISTRAR'S SIGNATURE <u>Wm. H. St. Louis</u>				24c. REGISTRAR'S SIGNATURE <u>Wm. H. St. Louis</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

